

# National Rural Health Mission

A Promise of  
Better Healthcare Service for the Poor

A summary of  
**Community Entitlements**  
and  
**Mechanisms for Community Participation and Ownership**  
for  
**Community Leaders**

Prepared for  
**Community Monitoring of NRHM - First Phase**





**SOCHARA****Community Health****Library and Information Centre (CLIC)****Community Health Cell****85/2, 1st Main, Maruthi Nagar,  
Madiwala, Bengaluru - 560 068.****Tel : 080 - 25531518****email : clic@sochara.org / chc@sochara.org****www.sochara.org**

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*Briefing Note Compiled by:* **Abhijit Das, Gitanjali Priti Bhatia**

*Illustrations by:* **Ganesh**

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## Preface

**T**he National Rural Health Mission has been launched with the objective of improving the access to quality healthcare services for the rural poor, especially women and children. The Mission recognizes that good health is an important component of overall socio-economic development and an improved quality of life.

The most significant aspect of NRHM is that it is not a new health scheme or programme but a new approach to providing healthcare services. Some of the important components of this approach is that it

- recognizes the importance of integrating the determinants of health, like nutrition, water and sanitation with healthcare systems
- aims at decentralizing planning and management
- integrates organizational structures—i.e. the different vertical health schemes
- improves delivery of healthcare services through upgrading and standardizing health centres
- introduces standards and guarantees for service quality and triangulated monitoring systems for assuring quality
- provides mechanisms for community participation and management

This short briefing note has been prepared by pooling together all the manuals and guidelines that have been prepared to guide the implementation of NRHM and highlights its key components which relate to Entitlements, Mechanisms for Community Participation and Yardsticks for Community Monitoring. It is expected that this information will prove useful for all those involved in the Community Monitoring processes at the district, block and village levels.

This briefing note has been prepared as a part of the Community Monitoring of NRHM (first phase) being implemented by the Advisory Group on Community Action.



## An Introduction to NRHM

**T**he Government of India launched the National Rural Health Mission (NRHM) on the 12th of April 2005. The vision of the mission is to undertake architectural correction of the health system and to improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

NRHM is a 7 years programme ending in the year 2012. It has time bound goals and its progress will be reported publicly by the government.

### Some of the goals of the Mission:

- Reduction in child and maternal mortality
- Universal access to public health care services along with public services for food and nutrition, sanitation and hygiene
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
- Access to integrated comprehensive primary health care

### Some of the Core Strategies through which the mission seeks to achieve its goals:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services
- Promote access to improved healthcare at household level through (ASHA)
- Health Plan for each village through Village Health Committee
- Strengthening existing sub-centre, PHCs and CHCs
- Preparation and Implementation of an inter-sectoral District Health Plan
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels

Unlike previous health programmes, the government has clearly defined the roles of Non governmental organization (NGOs) in the Mission. NGO's are not only included in institutional arrangement at National, State and District Levels but also they are supposed to play an important role in monitoring, evaluation and social audit.

**Source of Information:** Mission document <http://mohfw.nic.in/NRHM/Documents/NRHM%20Mission%20Document.pdf>

**For more Information** on NRHM vision, goals, objectives, strategies and outcomes go to:

1) Framework for Implementation. <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

2) Website on NRHM by Ministry of Health and Family Welfare <http://mohfw.nic.in/NRHM/NRHM.htm>



## Service Guarantees and Important Schemes and Provisions under NRHM

### Accredited Social Health Activist (ASHA)

With the launch of NRHM, the Government of India proposed Accredited Social Health Activist (ASHA) to act as the interface between the community and the public health system.

Since Sub centers were serving much larger population than they were expected to and ANMs were heavily overworked, one of the core strategies of NRHM is to promote access to improved healthcare at household level through ASHA.

- ASHA is a Health Activist in the community
- Every village will have 1 ASHA for every 1000 persons
- She will be selected in a meeting of the Gram Sabha
- She will be chosen from women (married/widowed/divorced between 25-45 years) residing in the village with minimum education up to VIIIth class.
- ASHA is accountable to the Panchayat
- ASHA will work from the Anganwadi Centre
- ASHA is honorary volunteer and she is entitled to receive performance based compensation. Her services to the community are Free of cost
- ASHA will receive trainings on care during pregnancy, delivery, post partum period, New born care, sanitation and hygiene

### Roles and Responsibilities

ASHA is responsible for creating Awareness on Health including

- Providing information to the community on nutrition, hygiene and sanitation
- Providing information on existing health services and mobilizing and helping the community in accessing health related services available at Health Centers
- Registering pregnant women and helping poor women to get BPL certification
- Counseling women on birth preparedness, safe delivery, breast feeding, contraception RTI/STI and care of young child
- Arranging escort/accompany pregnant women and children requiring treatment/admission to the nearest health centre.
- Promoting universal immunization
- Providing primary medical care for minor ailments. Keeping a drug kit containing generic AYUSH and allopathic formulations for common ailments
- Promoting construction of household toilets
- Facilitating preparation and implementation of the Village Health Plan through AWW, ANM, SHG members under the leadership of village health committee
- Organizing Health Day once/twice a month at the anganwadi with the AWW and ANM
- ASHA is also a Depot holder for essential services like IFA, OCP, Condoms, ORS DDK etc, issued by AWW

**Timeline:** Fully trained ASHA for every 1000 population/large-isolated habitations in 18 Special Focus States-30% by year 2007, 60% by 2009 and 100% by 2010



## Source of Information:

- (1) Guidelines on ASHA- It has been envisaged that states will have flexibility to adapt these guidelines keeping their local situations in view.  
<http://mohfw.nic.in/Guidelines%20on%20ASHA-Annex%201.pdf>
- (2) Framework for Implementation (\*) <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

## For more Information on ASHA go to:

- 1) Guidelines on JSY [http://mohfw.nic.in/dofw%20website/JSY\\_features\\_FAQ\\_Nov\\_2006.htm](http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm)
- 2) Website of Ministry of Health and Family Welfare  
<http://mohfw.nic.in/NRHM>

## Auxiliary Nurse Midwife (ANM)

ANM is a government paid health worker who provides free maternal and childcare services within a sub center area. The Mission seeks to provide minimum two ANMs at each Sub Health Centre to be fully supported by the Government of India.

### Primary tasks of ANM

- Registration of all pregnancies (ANM along with ASHA will ensure that all BPL women get benefits under Janani Suraksha Yojna)
- Ensure Minimum 4 antenatal check ups along with 100 IFA tablets and two T.T. Injections to pregnant women
- Appropriate and prompt referral in case of high-risk pregnancies
- Provide Skilled Attendance at home deliveries, post partum care and contraceptive advice
- Newborn Care (full immunization and Vitamin A doses to children, prevention and control of childhood diseases like malnutrition, infections etc.
- Curative Services like treatment for minor ailments

- Maintenance of all relevant records concerning mother, child and eligible couples in the area
- Providing information on different family planning and Contraception methods and Provision of Contraceptives
- Counseling and correct information on safe abortion services
- Coordinates services with AWWs, ASHA, Village Health & Sanitation Committee and PRI for observance of Health Day at AWW center at least once a month
- Coordination and supervision of ASHA
- The Untied grant to the Sub Center is kept in a joint account, which is operated, by the ANM and the local Sarpanch

ANM is answerable to Village Health and Sanitation committee, which will oversee her work.

## Source of Information:

Framework for Implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

## For more Information on JSY go to:

- 1) Guidelines on JSY [http://mohfw.nic.in/dofw%20website/JSY\\_features\\_FAQ\\_Nov\\_2006.htm](http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm)
- 2) Website of Ministry of Health and Family Welfare - <http://mohfw.nic.in/NRHM>

## JANANI SURAKSHA YOJANA (JSY)

JSY is meant to reduce maternal mortality and neo-natal mortality by promoting deliveries at health institutions by skilled personnel like doctors and nurses.

JSY is a 100% centrally sponsored scheme. It integrates cash assistance to women from poor families for enabling them to deliver in health institutions along with anti natal and post natal care.



The scheme applies differently to LPS and HPS. While states having low institutional delivery rates have been named as Low Performing States (LPS), the remaining states have been named as High Performing States (HPS). LPS states include the states of Uttar Pradesh, Uttaranchal, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa and HPS states include Maharashtra and Tamilnadu.

### Eligibility for Cash Assistance:

**LPS States** All pregnant women delivering in Government health centres like Sub-centre, PHC/CHC/FRU/general wards of District and state Hospitals or accredited private institutions. No age constraint

**HPS States** BPL pregnant women, aged 19 years and above

**LPS & HPS** All SC and ST women delivering in a government health centre like Sub-centre, PHC/CHC/FRU/general ward of District and state Hospitals or accredited private institutions. No age constraint

### Limitations of Cash Assistance for Institutional Delivery:

**In LPS States** All births, delivered in a health centre – Government or Accredited Private health institutions.

**In HPS States** Upto 2 live births.

### Scale of Cash Assistance for Institutional Delivery

Category	Rural Area		Total	Urban Area		Total
	Mother's Package	ASHA's Package	Rs.	Mother's Package	ASHA's Package	Rs.
LPS	1400	600	2000	1000	200	1200
HPS	700		700	600		600

Generally the ANM/ASHA should carry out the entire disbursement process.

### Assistance for Home Delivery

In LPS and HPS States, BPL pregnant women, aged 19 years and above, preferring to deliver at home is entitled to cash assistance of Rs. 500/- per delivery. Such cash assistance would be available only upto 2 live births and the disbursement would be done at the time of delivery or around 7 days before the delivery by ANM/ASHA/any other link worker. The rationale is that beneficiary would be able to use the cash assistance for her care during delivery or to meet incidental expenses of delivery.

### Role of ASHA or other link health worker associated with JSY

Along with fulfilling their usual duties of providing anti natal and post natal care to woman, ASHA/other health workers would be responsible for

- Identifying pregnant woman as a beneficiary of the scheme
- Assisting the pregnant woman to obtain necessary certifications
- Identifying a functional Government health centre or an accredited private health institution for referral and delivery
- Escorting the beneficiary women to the health center and stay with her till the woman is discharged

**Source of Information:** Website of Ministry of Health and Family Welfare

**For more Information** on need of BPL certification, Disbursement of Cash Assistance, flow of fund (from state district authority to ANM to ASHA), ASHA's package under JSY, Subsidizing cost of Caesarean Section, Grievance Redressal

cell, display of names of JSY beneficiaries in health centers go to: [http://mohfw.nic.in/dofw%20website/JSY\\_features\\_FAQ\\_Nov\\_2006.htm](http://mohfw.nic.in/dofw%20website/JSY_features_FAQ_Nov_2006.htm)



## Service Guarantees from Sub Health Center

**(Services provided at the Sub Center are Free of Cost for a person from BPL family)**

### Maternal Health

#### *Antenatal care:*

- Early registration of all pregnancies
- Minimum four antenatal check-ups
- General examination such as weight, BP, anaemia, abdominal examination, height and breast examination
- Iron and Folic Acid supplementation
- T.T.Injection, treatment of anaemia, etc.
- Minimum laboratory investigations like haemoglobin, urine albumen and sugar
- Identification of high-risk pregnancies and appropriate and prompt referral

#### *Intranatal care:*

- Promotion of institutional deliveries
- Skilled attendance at home deliveries as and when called for
- Appropriate and prompt referral

#### *Postnatal care:*

- A minimum of 2 postpartum home visits
- Initiation of early breast-feeding within half-hour of birth
- Counselling on diet and rest, hygiene, contraception, essential new born care, infant and young child feeding and STI/RTI and HIV/AIDS

### Child Health

- Promotion of exclusive breast-feeding for 6 months
- Full Immunization of all infants and children

- Correct doses of Vitamin A
- Prevention and control of childhood diseases like malnutrition, infections, etc.

### Family Planning and contraception

- Provision of contraceptives and counseling to adopt appropriate Family planning methods
- Counselling and appropriate referral for safe abortion services (MTP) for those in need

### Adolescent health care

Providing education, counselling and referral services Assistance to school health services.

### Control of local endemic diseases Disease surveillance

- Disinfection of water sources
- Promotion of sanitation including use of toilets and appropriate garbage disposal

### Curative Services

- Provide treatment for minor ailments including and First Aid in accidents and emergencies
- Appropriate and prompt referral
- Organizing Health Day at Anganwadi centres at least once in a month

### Training, Monitoring and Supervision

- Training of Traditional Birth Attendants and ASHA
- Coordinated services with AWWs, ASHA, Village Health and Sanitation Committee, PRI

### Record of Vital events

- Recording and reporting of Vital statistics including births and deaths, particularly of mothers and infants



- Maintenance of all the relevant records concerning mother, child and eligible couples in the area

The Sub Health Centre will be accountable to the Gram Panchayat and shall have a local Committee for its management, with adequate representation of Village Health and Sanitation Committee.

ANM and Multi purpose Health worker MPW works from the Subcentre and deliver the above-mentioned service with the help of ASHA.

### Funds

- The Gram Panchayat SHC Committee has the mandate to undertake construction and maintenance of SHC. An annual maintenance grant of Rupees 10,000 will be available to every SHC
- Every SHC gets Rs.10,000 as Untied grants for local health action. The resources could be used for any local health activity for which there is a demand. The fund would be kept in a joint account to be operated by the ANM and the local Sarpanch

### Time Line:

- 2 ANM Sub Health Centres strengthened/ established to provide service guarantees as per IPHS, in 1,75,000 places - 30% by 2007, 60% by 2009, 100% by 2010
- Untied grants provided to each Sub Centre to promote local health action. 50% by 2007, 100% by 2008
- Annual maintenance grant provided to every Sub Centre - 50% by 2007, 100% by 2008
- Procurement and logistics streamlined to ensure availability of drugs and medicines at Sub Centres- 50% by 2007, 100% by 2008

### Source of Information:

- 1) Framework for Implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

### For more Information go to:

- 1) Guidelines for VHSCs, SCs, PHCs AND CHCs [http://mohfw.nic.in/NRHM/Documents/Guidelines\\_of\\_](http://mohfw.nic.in/NRHM/Documents/Guidelines_of_)

[untied\\_funds\\_NRHM.pdf](#)

- 2) IPHS for Subcenters [http://mohfw.nic.in/NRHM/Documents/IPHS\\_for\\_SUBCENTRES.pdf](http://mohfw.nic.in/NRHM/Documents/IPHS_for_SUBCENTRES.pdf)

## Services Guarantees from Primary Health Centre (PHC)

**(All services provided at PHC are free of cost for BPL families)**

Every PHC has to provide OPD services, Inpatient Service, referral service and 24 hours emergency service for all cases needing routine and emergency treatment including treatment of local diseases.

**All services provided by Sub centers are also provided by PHC.**

Some additional services provided in a PHC are as follows:

### Maternal Health

- 24-hour delivery services both normal and assisted
- Appropriate and prompt referral for cases needing specialist care
- Pre-referral management (Obstetric first-aid)
- Facilities under Janani Suraksha Yojana

### Family Planning

- Permanent methods of Family Planning
- Facility for Medical Termination of Pregnancies (wherever trained personnel and facility exists)

### Treatment of RTI/ STIs

#### Basic laboratory services

#### Referral services

Appropriate and prompt referral of cases needing specialist care including:

- Stabilisation of patient



- Appropriate support for patient during transport
- Providing transport facilities

A Charter of Citizen's Health Rights should be prominently displayed outside all PHCs.

The Primary Health Centre (not at the block level) will be responsible to the elected representative of the Gram Panchayat where it is located.

The Block level PHC will have involvement of Panchayati Raj elected leaders in its management even though Rogi Kalyan Samiti would also be formed for day-to-day management of the affairs of the hospital.

The Mission seeks to provide minimum three Staff Nurses to ensure round the clock services in every PHC.

### Funds

- Each PHC is entitled to get an annual maintenance grant of Rs. 50,000 for construction and maintenance of physical infrastructure. Provision for water, toilets, their use and their maintenance, etc, has to be priorities. PHC level Panchayat Committee/Rogi Kalyan Samiti will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure
- Every PHC is entitled to get Rs. 25,000 as Untied grants for local health action. The resources could be used for any local health activity for which there is a demand

### Time Line:

- 30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS - 30% by 2007, 60% by 2009 and 100% by 2010
- Untied grants provided to each PHC to promote local health action - 50% by 2007 and 100% by 2008
- Annual maintenance grant provided to every PHC - 50% by 2007 and 100% by 2008
- Procurement and logistics streamlined to ensure availability of drugs and medicines at PHCs - 50% by 2007 and 100% by 2008

### Source of Information:

Framework for Implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

### For more Information go to:

Guidelines for VHSCs, SCs, PHCs AND CHCs [http://mohfw.nic.in/NRHM/Documents/Guidelines\\_of\\_untied\\_funds\\_NRHM.pdf](http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf)

## Service Guarantees from Community Health Centre (CHC)

- Care of routine and emergency cases in surgery and medicine
- 24-hour delivery services including normal and assisted deliveries
- Essential and Emergency Obstetric Care including surgical interventions
- Full range of family planning services
- Safe Abortion Services
- Newborn Care and Routine and Emergency Care of sick children
- Diagnostic services through the microscopy centers
- Blood Storage Facility
- Essential Laboratory Services
- Referral Transport Services
- All National Health Programmes should be delivered through the CHCs. e.g. HIV/AIDS Control Programme, National Leprosy Eradication Programme, National Programme for Control of Blindness

Over the Mission period, the Mission aims at bringing all the CHCs on a par with the IPHS to provide round the clock hospital-like services. According to IPHS, it is mandatory to display Charter of Citizen's Health Rights outside all CHCs. The dissemination and display of charter is the



responsibility of Block Health Monitoring and Planning Committee.

According to IPHS, it is mandatory for every CHC to have "Rogi Kalyan Samiti" to ensure accountability.<sup>^</sup>

Mission also seeks to provide separate AYUSH set up in each CHC.

### Funds

- Every CHC gets Annual maintenance grant of Rs. 1 lakh for construction and maintenance of physical infrastructure. Rogi Kalyan Samiti/Block Panchayat Samiti has a mandate to undertake construction and maintenance of CHC
- Every CHC gets Rupees 50,000 as Untied grants for local health action. The resources could be used for any local health activity for which there is a demand

### Time Line

- 6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS-30% by 2007, 50% by 2009 and 100% by 2012
- Untied grants provided to each CHC to promote local health action- 50% by 2007 and 100% by 2008
- Annual maintenance grant provided to every CHC -50% by 2007 and 100% by 2008
- Procurement and logistics streamlined to ensure availability of drugs and medicines at CHCs-50% by 2007 and 100% by 2008

### Source of Information:

- 1) Framework for Implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>
- 2) IPHS for CHC(^) [http://mohfw.nic.in/NRHM/Documents/Draft\\_CHC.pdf](http://mohfw.nic.in/NRHM/Documents/Draft_CHC.pdf)

**For more Information** on Guidelines for Village Health and Sanitation Committees, Sub Centres, PHCs and CHCs go to: [http://mohfw.nic.in/NRHM/Documents/Guidelines\\_of\\_untied\\_funds\\_NRHM.pdf](http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf)

## AYUSH

The term AYUSH covers Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy. These systems are popular in a large number of States in the country. e.g. Ayurved system is popular in the States of Madhya Pradesh, Rajasthan, and Orissa, the Unani system is particularly popular in Tamil Nadu and Maharashtra. This is to imply that the AYUSH systems of medicine and its practices are well accepted by the community, particularly, in rural areas. The medicines are easily available and prepared from locally available resources, economical and comparatively safe.

One of the objectives of the mission is to revitalize local health traditions and mainstream AYUSH into the public health system.

### Modalities For Integration

- For mainstreaming, the personnel of AYUSH may work under the same roof of the Health Infrastructure, i.e., PHC, CHC; However, separate space should be allocated exclusively for them in the same building
- The Doctors under the Systems of AYUSH are required to practice as per the terms & conditions laid down for them by the appropriate Regulatory Authorities
- Provision of one Doctor of any of the AYUSH systems as per the local acceptability assisted by a Pharmacist in PHC
- Provision of one Specialist of any of the AYUSH systems as per the local acceptability assisted by a Pharmacist in CHC
- Supply of appropriate medicines pertaining of AYUSH systems
- The already existing AYUSH infrastructure should be mobilized. AYUSH dispensaries that are not functioning well should be merged with the PHC or CHC barring which, displacement of AYUSH clinic is not advised
- Cross referral between allopathic and AYUSH streams should be encouraged based on the need for the same



- AYUSH Doctors shall be involved in IEC, health promotion and also supervisory activities
- The IPHS pertaining to AYUSH and also the detailed manpower and other requirements and financial projections for the same will be provided by the Department of AYUSH for further consideration

**Source of Information:**

Mainstreaming of AYUSH Systems in the National Health Care Delivery System- [Mohfw.nic.in/ayush%2015th%20march.pdf](http://mohfw.nic.in/ayush%2015th%20march.pdf)

**For more Information go to:**

Website of Department of AYUSH <http://indianmedicine.nic.in/>



## Community Participation in NRHM

### Village Health and Sanitation Committee (VHSC)

**V**illage level Health and Sanitation Committee will be responsible for the Village Health Plans.

This committee would be formed at the level of the revenue village (more than one such villages may come under a single Gram Panchayat).

#### Composition

The Village Health Committee would consist of:

- Gram Panchayat members from the village
- ASHA, Anganwadi Sevika, ANM
- SHG leader, the PTA/MTA Secretary, village representative of any Community based organisation working in the village, user group representative

The chairperson would be the Panchayat member (preferably woman or SC/ST member) and the convenor would be ASHA; where ASHA not in position it could be the Anganwadi Sevika of the village.

#### Training

The members would be given orientation training to equip them to provide leadership as well as plan and monitor the health activities at the village level.

#### Grants available

- Every village with a population of upto 1500 gets an annual Untied grant of up to Rs. 10,000, after

constitution and orientation of VHSC. The Untied grant to be used by this committee for household surveys, health camps, sanitation drives, revolving fund etc.

- A revolving fund for providing referral and transport facilities for emergency deliveries as well as immediate financial needs for hospitalization would also be operated by the VHSC

#### *Some roles of the VHSC*

- Create Public Awareness about the essentials of health programmes, with focus on People's knowledge of entitlements to enable their involvement in the monitoring
- Discuss and develop a Village Health Plan based on an assessment of the village situation and priorities identified by the village community
- Analyse key issues and problems related to village level health and nutrition activities, give feedback on these to relevant functionaries and officials. Present an annual health report of the village in the Gram Sabha
- Participatory Rapid Assessment to ascertain the major health problems and health related issues in the village. Mapping will be done through participatory methods with involvement of all strata of people. The health mapping exercise shall provide quantitative and qualitative data to understand the health profile of the village
- Maintenance of a village health register and health information board/calendar: The health register and board will have information about mandated services, along with services actually rendered to all pregnant women, new born and infants, people suffering from chronic diseases etc. Similarly dates of visit and activities expected to be performed during each visits by health functionaries may be displayed and monitored by means of a Village health calendar
- Ensure that the ANM and MPW visit the village on the fixed days and perform the stipulated activity; oversee the work of village health and nutrition functionaries like ANM, MPW and AWW



- Get a bi-monthly health delivery report from health service providers during their visit to the village. Discuss the report submitted by ANM and MPW and take appropriate action

### Time Line

Village Health and Sanitation Committee constituted in over 6 lakh villages and untied grants provided to them - 30% by 2007, 100% by 2010

Untied grants provided to each Village Health and Sanitation Committee to promote local health action. 50% by 2007, 100% by 2008

### Source of Information:

Framework for implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

### For more Information go to:

Guidelines for VHSCs, SCs, PHCs AND CHCs [http://mohfw.nic.in/NRHM/Documents/Guidelines\\_of\\_untied\\_funds\\_NRHM.pdf](http://mohfw.nic.in/NRHM/Documents/Guidelines_of_untied_funds_NRHM.pdf)

## PHC Monitoring and Planning Committee

This Committee monitors the functioning of Sub-centres operating under jurisdiction of the PHC and develops PHC health plan after consolidating the village health plans.

### Composition

- 30% members from PRI (from the PHC coverage area; 2 or more sarpanchs of which at least one is a woman)
- 20% members non-official representatives from VHSC, (under the jurisdiction of the PHC, with annual rotation to enable representation from all the villages)
- 20% members representatives from NGOs / CBOs and People's organizations working on Community health and health rights in the area covered by the PHC
- 30% members representatives of the Health and Nutrition Care providers, including the Medical Officer – Primary Health Centre and at least one ANM working in the PHC area
- Chairperson: Panchayat Samiti member, Executive chairperson: Medical officer of the PHC, Secretary: NGO/CBO representatives

### Role & Responsibilities

- Consolidation of the village health plans and charting out the annual health action plan in order of priority
- Presentation of the progress made at the village level, achievements, actions taken and difficulties faced followed by discussion on the progress of the achievements of the PHC, concerns and difficulties faced and support received to improve the access to health facilities in the area of that particular PHC
- Ensure that the Charter of citizen's health rights is disseminated widely and displayed out side the PHC informing the people about the medicine facilities available at the PHC, timings of PHC and the facilities available free of cost. A suggestion box can be kept for the health care facility users to express their views about the facilities. These comments will be read at the coordination committee meeting to take necessary action
- Monitoring of the physical resources like, infrastructure, equipments, medicines, water connection etc at the PHC and inform the concerned government officials to improve it
- Discuss and develop a PHC Health Plan based on an assessment of the situation and priorities identified by representatives of village health committees and community based organizations
- Share the information about any health awareness programme organized in the PHC's jurisdiction, its achievements, follow up actions, difficulties faced etc.
- Coordinate with local CBOs and NGOs to improve the health scenario of the PHC area



- Review the functioning of Sub-centres operating under jurisdiction of the PHC and taking appropriate decisions to improve their functioning
- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee

### Time Line:

Systems of community monitoring put in place - 50% by 2007 and 100% by 2008.

### Source of Information:

Framework for implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

## Block Monitoring and Planning Committee

This Committee monitors the progress made at the PHC level health facilities in the block, including CHC and develops annual action plan for the Block after consolidating PHS level health plans.

### Composition

- 30% members representatives of the Block Panchayat Samiti (Adhyaksha/Adhyakshika or members with at least one woman)
- 20% members non-official representatives from the PHC health committees in the block, with annual rotation to enable representation from all PHCs over time
- 20% members representatives from NGOs/CBOs and People's organizations working on Community health and health rights in the block, and involved in facilitating monitoring of health services
- 20% members officials such as the BMO, the BDO, selected MO's from PHCs of the block
- 10% members representatives of the CHC level Rogi Kalyan Samiti

- Chairperson: Block Panchayat Samiti representative, Executive chairperson: Block medical officer, Secretary: NGO / CBO representatives

### Role & Responsibilities

- Consolidation of the PHC level health plans and charting out of the annual health action plan for the block.
- Review of the progress made at the PHC levels, difficulties faced, actions taken and achievements made, followed by discussion on any further steps required to be taken for further improvement of health facilities in the block, including the CHC
- Analysis of records on neonatal and maternal deaths; and the status of other indicators, such as coverage for immunization and other national programmes
- Monitoring of the physical resources like, infrastructure, equipments, medicine, water connection etc at the CHC; similar exercise for the manpower issues of the health facilities that come under the jurisdiction of the CHC
- Coordinate with local CBOs and NGOs to improve the health services in the block
- Review the functioning of Sub-centres and PHCs operating under jurisdiction of the CHC and taking appropriate decisions to improve their functioning
- Initiate appropriate action on instances of denial of right to health care reported or brought to the notice of the committee; initiate an enquiry if required and table report within two months in the committee. The committee may also recommend corrective measures to the district level

### Time Line:

Systems of community monitoring put in place - 50% by 2007 and 100% by 2008.

### Source of Information:

Framework for implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>



## District Health Monitoring and Planning Committee

This Committee contributes to the development of District Health plan.

### Composition

- 30% members representatives of the Zilla Parishad (esp. convenor and members of its Health committee)
- 25% members district health officials, including the District Health Officer/Chief Medical Officer and Civil Surgeon or officials of parallel designation, along with representatives of the District Health planning team including management professionals
- 15% members non-official representatives of block committees, with annual rotation to enable successive representation from all blocks
- 20% members representatives from NGOs/CBOs and People's organizations working on Health rights and regularly involved in facilitating Community based monitoring at other levels (PHC/block) in the district
- 10% members should be representatives of Hospital Management Committees in the district
- Chairperson: Zilla Parishad representative, preferably convenor or member of the Zilla Parishad Health committee, Executive chairperson: CMO/CMHO/DHO or officer of equivalent designation, Secretary: NGO/CBO representatives

### Role & Responsibilities

- Discussion on the reports of the PHC health committees
- Financial reporting and solving blockages in flow of resources if any
- Infrastructure, medicine and health personnel

related information and necessary steps required to correct the discrepancies

- Progress report of the PHCs emphasising the information on referrals utilisation of the services, quality of care etc.
- Contribute to development of the District Health Plan, based on an assessment of the situation and priorities for the district. This would be based on inputs from representatives of PHC health committees, community based organisations and NGOs
- Ensuring proper functioning of the Hospital Management Committees
- Discussion on circulars, decisions or policy level changes done at the state level; deciding about their relevance for the district situation
- Taking cognizance of the reported cases of the denial of health care and ensuring proper redressal

### Time Line:

Systems of community monitoring put in place- 50% by 2007 and 100% by 2008.

### Source of Information:

Framework for implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

## State Health Monitoring and Planning Committee

This Committee reviews and contributes to the development of State Health plan.

### Composition

- 30% of total members should be elected representatives, belonging to the State legislative body (MLAs/MLCs) or Convenors of Health committees of Zilla Parishads of selected districts (from different regions of the state) by rotation



- 15% would be non-official members of district committees, by rotation from various districts belonging to different regions of the state
- 20% members would be representatives from State health NGO coalitions working on Health rights, involved in facilitating Community based monitoring
- 25% members would belong to State Health Department
- Secretary Health and Family Welfare, Commissioner Health, relevant officials from Directorate of Health Services (incl. NRHM Mission Director) along with Technical experts from the State Health System Resource Centre/Planning cell
- 10% members would be officials belonging to other related departments and programmes such as Women and Child Development, Water and Sanitation, Rural development
- The Chairperson would be one of the elected members (MLAs)
- The executive chairperson would be the Secretary Health and Family Welfare
- The secretary would be one of the NGO coalition representatives

### Role & Responsibilities

- The main role of the committee is to discuss the programmatic and policy issues related to access to health care and to suggest necessary changes
- This committee will review and contribute to the development of the State health plan, including the plan for implementation of NRHM at the state level; the committee will suggest and review priorities and overall programmatic design of the State health plan
- Key issues arising from various District health committees, which cannot be resolved at that level (especially relating to budgetary allocations, recruitment policy, programmatic design etc.)

would be discussed an appropriate action initiated by the committee. Any administrative and financial level queries, which need urgent attention, will be discussed

- Institute a health rights redressal mechanism at all levels of the health system, which will take action within a time bound manner. Review summary report of the actions taken in response to the enquiry reports
- Operationalising and assessing the progress made in implementing the recommendations of the NHRC, to actualize the Right to health care at the state level
- The committee will take proactive role to share any related information received from GOI and will also will share achievements at different levels. The copies of relevant documents will be shared

### Time Line:

Systems of community monitoring put in place - 50% by 2007 and 100% by 2008.

### Source of Information:

Framework for implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

## Rogi Kalyan Samiti (RKS)

For efficient management of Health Institutions NRHM has proposed Rogi Kalyan Samiti (RKS)/Patient Welfare Committee/Hospital Management Committee (HMC) . This initiative is taken to bring in the community ownership in running of rural hospitals and health centres, which will in turn make them accountable and responsible.#

### Broad Objectives of RKS#

- Ensure compliance to minimal standard for facility and hospital care
- Ensure accountability of the public health providers to the community



- Upgrade and modernize the health services provided by the hospital
- Supervise the implementation of National Health Programme
- Set up a Grievance Mechanism System

Apart from this, RKS at PHC and CHC will have the mandate to undertake and supervise improvement and maintenance of physical infrastructure. RKS would also develop annual plans to reach the IPHS standards.\*

**RKS would be a registered society. It may consist of following members#**

- Group of users i.e. people from community
- Panchayati Raj representatives
- NGOs
- Health professionals

According to IPHS, it is mandatory for every CHC to have "Rogi Kalyan Samiti" to ensure accountability.^

### Grants

To motivate the states to set up RKSs, a support of Rs.5.0 lakhs per rural hospital, Rs.1.00 lakh per CHC and Rs.1.00 per PHC per annum would be given to these societies through states. The societies would be eligible for these grants only where they are authorized by the States to retain the user charges at the institution level.\*

### Time Line\*:

- Rogi Kalyan Samitis/Hospital Development Committees established in all CHCs/Sub Divisional Hospitals/ District Hospitals - 50% by 2007, 100% by 2009
- One time support to RKSs at Sub Divisional/ District Hospitals - 50% by 2007, 100% by 2008

### Source of Information:

- 1) Framework for implementation (\*) <http://mohfw.nic.in/NRHM/Documents/NRHM%20%20Framework%20for%20Implementation.pdf>
- 2) Guidelines for IPHS for CHC(^)
- 3) Guidelines for Rogi Kalyan Samiti (#) <http://mohfw.nic.in/NRHM/RKS.htm>



## Some Frameworks for Community Monitoring

### Indian Public Health Standards (IPHS)

IPHS are being prescribed to provide optimal expert care to the community and to achieve and maintain an acceptable standard of quality of care. These standards help in monitoring and improving the functioning of public health centers.#

IPHS for CHCs provides for “Assured services” that should be available in a Community health centre along with minimum requirements for delivering these services such as:

- Minimum clinical and supporting manpower requirement
- Equipments
- Drugs
- Physical Infrastructure
- Charter of Patients’ rights
- Requirement of quality control
- Quality assurance in service delivery-standard treatment protocol#

Similar standards are being developed for PHCs & Sub Center.\*

Over the Mission period, the Mission aims at bringing all the CHCs on a par with the IPHS in a gradual manner. In the process, all the CHCs would be operationalized as first Referral Units (FRUs) with all facilities for emergency obstetric care. \*

It will be for the States to decide on the configuration of PHCs to meet IPH Standards and offer 24X7 services

including safe delivery. The RKS would develop annual plans to reach the IPH standards.\*

#### Time line\*

In the first six months since the launch of the mission, following work should have been completed:

- Selection of and 2 CHCs in each State for upgradation to IPHS
- Release of funds for upgradation of two CHCs per district to IPHS
- 2 ANM Sub Health Centres strengthened/ established to provide service guarantees as per IPHS, in 1,75,000 places- 30% by 2007, 60% by 2009 and 100% by 2010
- 30,000 PHCs strengthened/established with 3 Staff Nurses to provide service guarantees as per IPHS - 30% by 2007, 60% by 2009 and 100% by 2010
- 6500 CHCs strengthened/established with 7 Specialists and 9 Staff Nurses to provide service guarantees as per IPHS - 30% by 2007, 50% by 2009 and 100% by 2012

#### Source of Information:

1) Framework for Implementation (\*) [http:// mohfw.nic .in/NRHM/Documents/NRHM%20-%20Framework %20for%20Implementation.pdf](http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf)

2) IPHS for CHC (#) - [http://mohfw.nic. in/NRHM/ Documents/Draft\\_CHC.pdf](http://mohfw.nic.in/NRHM/Documents/Draft_CHC.pdf)

#### For more Information go to:

Link given on Ministry of Health and Family Welfare website: <http://mohfw.nic.in/NRHM/iphs.htm>

### Charter of Citizen’s Health Rights

Charter of Citizen’s Health Rights seeks to provide a framework which enables citizens to know.

- What services are available?
- The quality of services they are entitled to.



- The means through which complaints regarding denial or poor qualities of services will be addressed.#

A Charter of Citizen's Health Rights should be prominently displayed outside all District Hospitals, CHCs and PHCs. While IPHS makes the display mandatory for every CHC.\*

The dissemination and display of charter is the responsibility of Health Monitoring and Planning Committee at that level. E.g. Block Health Monitoring and Planning Committee has the responsibility to ensure display of the charter at CHC.\*

While the Charter would include the services to be given to the citizens and their rights in that regard, information regarding grants received, medicines and vaccines in stock etc. would also be exhibited. Similarly, the outcomes of various monitoring mechanisms would be displayed at the CHCs in a simple language for effective dissemination.\*

The charter seeks to increase transparency that would help the community to better monitor the health services.\*

### Source of Information:

1) Framework for implementation(\*) <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

2) IPHS for CHC(#)- [http://mohfw.nic.in/NRHM/Documents/Draft\\_CHC.pdf](http://mohfw.nic.in/NRHM/Documents/Draft_CHC.pdf)

**For more information go to:**

Link given on Ministry of Health and Family Welfare website: <http://mohfw.nic.in/NRHM/iphs.htm>

## Concrete Service Guarantees

Concrete Service Guarantees that NRHM provide are the benchmarks against which mission functioning can be monitored and its success can be measured. These guarantees are as follows:

- Skilled attendance at all Births

- Emergency Obstetric care
- Basic neonatal care for new born
- Full coverage of services related to childhood diseases/health conditions
- Full coverage of services related to maternal diseases/health conditions
- Full coverage of services related to low vision and blindness due to refractive errors and cataract.
- Full coverage for curative and restorative services related to leprosy
- Full coverage of diagnostic and treatment services for tuberculosis
- Full coverage of preventive, diagnostic and treatment services for vector borne diseases
- Full coverage for minor injuries/illness (all problems manageable as part of standard outpatient care upto CHC level)
- Full coverage of services inpatient treatment of childhood diseases/health conditions
- Full coverage of services inpatient treatment of maternal diseases/health conditions including safe abortion care (free for 50% user charges from APL)
- Full coverage of services for Blindness, life style diseases, hypertension etc.
- Full coverage for providing secondary care services at Sub-district and District Hospital
- Full coverage for meeting unmet needs and spacing and permanent family planning services
- Full coverage of diagnostic and treatment services for RI/STI and counseling for HIV-AIDS services for adolescents
- Health education and preventive health measures



**Time Line:**

SHCs/PHCs/CHCs/Sub Divisional Hospitals/ District Hospitals fully equipped to develop intra health sector convergence, coordination and service guarantees for family welfare, vector borne disease programmes, TB, HIV/AIDS, etc.-30% by 2007, 50% by 2008, 70% by 2009 and 100% by 2012

Institution-wise assessment of performance against assured service guarantees carried out-30% by 2008,

60% by 2009 and 100% by 2010.

**Source of Information:**

Framework for Implementation <http://mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>

**For more information on:**

Institution wise service guarantees go to Annex-III of Framework for Implementation.





## Annexure

### Model Citizens Charter for CHCs and PHCs

#### 1. Preamble

Community Health Centres and Primary Health Centres exist to provide health care to every citizen of India within the allocated resources and available facilities. The Charter seeks to provide a framework which enables citizens to know.

- what services are available?
- the quality of services they are entitled to.
- the means through which complaints regarding denial or poor qualities of services will be addressed.

#### 2. Objectives

- to make available medical treatment and the related facilities for citizens.
- to provide appropriate advice, treatment and support that would help to cure the ailment to the extent medically possible.
- to ensure that treatment is best on well considered judgment, is timely and comprehensive and with the consent of the citizen being treated.
- to ensure you just awareness of the nature of the ailment, progress of treatment, duration of treatment and impact on their health and lives, and
- to redress any grievances in this regard.

#### 3. Commitments of the Charter

- to provide access to available facilities without discrimination.
- to provide emergency care, if needed on reaching the CHC/PHC.
- to provide adequate number of notice boards detailing the location of all the facilities.
- to provide written information on diagnosis, treatment being administered.
- to record complaints and designate appropriate officer, who will respond at an appointed time, that may be same day in case of inpatients and the next day in case of out patients.

#### 4. Component of service at CHCs

- access to CHCs and professional medical care to all.
- making provision for emergency care after main treatment hour whenever needed.



- informing users about available facilities, costs involved and requirements expected of them with regard to the treatment in clear and simple terms.
- informing users of equipment out of order.
- ensuring that users can seek clarifications and assistance in making use of medical treatment and CHC facility.
- informing users about procedures for reporting in-efficiencies in services or nonavailability of facilities.

## **5. Grievance redressal**

- grievances that citizens have will be recorded.
- there will be a designated officer to respond to the request deemed urgent by the person recording the grievance.
- aggrieved user after his/her complaint recorded would be allowed to seek a second opinion within the CHC.
- to have a public grievance committee outside the CHC to deal with the grievances that are not resolved within the CHC.

## **6. Responsibilities of the users**

- users of CHC would attempt to understand the commitments made in the charter.
- user would not insist on service above the standard set in the charter because it could negatively affect the provision of the minimum acceptable level of service to another user.
- instruction of the CHC's personnel would be followed sincerely, and
- in case of grievances, the redressal mechanism machinery would be addressed by users without delay.

## **7. Performance audit and review of the charter**

- performance audit may be conducted through a peer review every two or three years after covering the areas where the standards have been specified.







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Centre for Health and Social Justice (CHSJ)  
3-C, First Floor, H-Block, Saket, New Delhi - 110 017.  
Tel.: +91 11 40517478 Telefax: +91 11 26536041  
E-mail: [chs@chs.org](mailto:chs@chs.org) Website: [www.chsj.org](http://www.chsj.org)